STATE OF CALIFORNIA -- HEALTH AND WEL RE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-8097

January 17, 1984

ALL-COUNTY LETTER NO. 84-10

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IN-HOME SUPPORTIVE SERVICES NOTICES OF ACTION

REFERENCE:

The Department has developed the attached In-Home Supportive Services (IHSS) Notices of Action for your immediate use. The copies are camera-ready for duplication by counties. After the notices are printed, they may be ordered from the Department of Social Services' (DSS) warehouse.

These new notices meet the requirements contained in Welfare & Institutions Code (W&IC) Sections 12300.2 and 12301, amended by Sections 116.5 and 116.7 of Chapter 323, Statutes of 1983 (Assembly Bill 223), the 1983/84 FY budget trailer bill.

The new notices are:

NA 690 - Approval
NA 690A - Denial
NA 690B - Reassessment
NA 690C - Discontinuance

As the requirements of AB 223 were effective upon its passage, these notices were developed at the State level to transmit as quickly as possible a uniform series of acceptable IHSS notices. Based upon this new law, counties will be required to provide recipients with the new Reassessment Notice (NA 690B) after any reassessment of need whether or not a change in authorized services and/or hours occur. As there was no appropriation in the bill for this activity, counties are to utilize existing resources for this requirement.

These IHSS notices are mandatory effective immediately for use by the counties without exception. Counties may no longer use existing SOC 239's or county-developed IHSS Notice of Action forms. If you wish to submit for State review and approval county-developed IHSS notices that meet AB 223 requirements, the proposed IHSS notices should be sent to:

State Department of Social Services
Adult Services Bureau
Attention: Pete Hilliard
744 P Street, M.S. 5-126
Sacramento, CA 95814

Written approval from SDSS must be secured before using county forms in lieu of the State-issued series.

Spanish-translated notices will be sent approximately one month after receipt of this letter. Translated notices in other languages are available upon request by contacting the DSS Language Services Unit at (916) 323-9562.

Also attached to this letter are instructions for completing the notices. If you have any questions about the notices or their instructions, please contact Pete Hilliard at (916) 322-8097.

LOREN D. SUTER
Deputy Director
Adult and Family Services Division

Attachments

cc: CWDA

d. Reassessment Notice

(1) Completion of Reassessment Notice when a change in authorized hours occurs for one or more tasks:

Under the column "Previous Hours Authorized", "Hours Now Authorized", and "Increase or Decrease", check applicable boxes and insert the hours of increase, decrease, or zero when there is no change. Enter the number of hours for specific tasks under Previous Hours Authorized and Hours Now Authorized even though there may be no change in the number of service hours for certain tasks.

Example (one case)	Previous Hours Authorized	Hours Now Authorized	Increase or Decrease
Domestic Services	6	6	0
Prepare Meals	2	4	+2
Meal Cleanup	2	3	+1

(2) Completion of Reassessment Notice when no change in authorized hours occurs for any task:

Leave the column "Previous Hours Authorized" blank. Under "Hours Now Authorized", insert the current authorized hours for each specific task. Under the column, "Increase or Decrease", leave blank.

(3) Complete the Monthly Authorization section on all forms as it appears on the Needs Assessment form. On the Reassessment form, insert the totals for Previous Hours Authorized, Hours Now Authorized, and Increase or Decrease, when there is a change (example below). When there is no change, insert only the total for "Hours Now Authorized".

Example:

	Previous Hours Authorized	Hours Now Authorized	Increase or Decrease
Monthly Authorization:			
Total Weekly Hours x 4.33	10	8	-2
Add Domestic Services Hours	6	6	0
Adds Heavy Cleaning/Yard Abatement	0	0	0
TOTAL MONTHLY HOURS	16	14	-2
Restaurant Allowance:	$ 0		

INSTRUCTIONS FOR NEW IHSS NOTICE OF ACTION FORMS

1. APPROVAL, NA 690 (10-83)

2. DENIAL, NA 690A (10-83)

3. REASSESSMENT, NA 690B (10-83)

4. DISCONTINUANCE, NA 690C (10-83)

Use the Reassessment form whether or not a change in services and hours is authorized at time of reassessment. Check the appropriate box for "no change" or "change" and enter the date of reassessment.

1. Be certain that only items which will apply are checked and that required information is inserted following boxes which are checked.

2. For income eligible recipients, complete Share of Cost information on all forms, including Reassessment form sections "Was" and "Now", even though the Share of Cost might be unchanged.

3. Completion of Hours Authorized on all forms:

   a. Approval Notice

      Under the column "Hours Authorized", check boxes for applicable service categories and insert the number of hours authorized for each task. This information appears on the Needs Assessment form and must be similarly completed on the Approval form.

   b. Denial Notice

      Under the column "Hours Assessed", check boxes for applicable service categories and insert the number of hours for each task which had been assessed as a need despite denial of the application for services. Completing this section will be necessary only when a needs assessment has been completed. This ensures that the applicant is provided full information on the level of care assessed and denied.

   c. Discontinuance Notice

      Under the column "Hours Previously Authorized", check boxes for applicable service categories and insert the number of hours for each task which the recipient has been receiving, all of which will be discontinued.

(4) Be certain to insert the applicable State Deppartment of Social Services' Manual of Policies and Procedures Section(s) on form used. This is necessary and legally mandated.

(5) Complete remainder of the form as required and be sure the assigned worker signs his/her name as the Service Worker.

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION — APPROVAL

COUNTY STAMP

NOTE: *This notice relates only to your social services. It does* NOT *affect your receipt of SSI/SSP or Social Security.*
KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

CASE NUMBER

DATE MAILED

THE ITEMS CHECKED BELOW APPLY TO YOU:

☐ Your application for In-Home Supportive Services has been approved beginning: _____.

☐ Your Share of Cost has been determined as follows:

Your income that was counted: $ _____
Minus SSI/SSP benefit level: — $ _____
Your Share of Cost: $ _____

SERVICES	HOURS AUTHORIZED
☐ **Domestic Services per Month:** Sweep, vacuum, etc; wash kitchen counters, etc; clean bathroom; store food, supplies; take out garbage; dust, pick up; clean oven and stove; clean, defrost refrigerator, bring in fuel; and change bed linen, make bed.	
☐ **Nonmedical Personal Services per Week:**	
*Respiration Assistance	
*Bowel, bladder care	
*Feeding	
*Routine bed baths	
*Dressing	
*Menstrual care	
*Ambulation	
*Move in/out of bed	
*Bathe, oral hygiene/grooming	
*Rub skin, repositioning, help on/off seats, etc.	
*Care/assist with prosthesis	
TOTAL NON-MEDICAL PERSONAL:	
☐ **Monthly Authorization:**	
Total weekly hours x 4.33:	
Add Domestic Services hours: +	
Add heavy cleaning/yard abatement: +	
TOTAL MONTHLY HOURS:	
Restaurant Allowance: $	

SERVICES	HOURS AUTHORIZED
☐ **Related Services per Week:**	
**Prepare meals	
**Meal clean up, menu	
Routine laundry	
Shopping for food	
Other shopping errands	
TOTAL RELATED:	
☐ **Transportation Services per Week:**	
Medical appointment	
To alternative resources	
TOTAL TRANSPORTATION:	
☐ **Protective Supervision per Week:**	
☐ **Teaching/Demonstration per Week:**	
☐ ***Paramedical Services per Week:**	
☐ **Heavy cleaning (when indicated)**	
☐ **Yard hazard abatement (when indicated)**	

☐ You are the only person counted in your household.

☐ You are receiving services based on _____ people living in your household.

☐ You have met the criteria of 20 hours or more in starred (*) services as prescribed by law which enables you to receive an advance payment to pay your own provider. **If you want to receive this advance payment, contact your service worker.** Double starred (**) services are included in the 20 hours ONLY when assistance with feeding is required.

☐ The above action is supported by Federal and State Law and State Department of Social Services Manual of Policies and Procedures Section(s):

You must report immediately and changes that might affect your eligibility or need for In-Home Supportive Services such as a change in income, property, living arrangements, medical condition or ability to work. If you have any questions or think additional facts should be considered contact:

Service Worker: _____ Telephone: _____

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING.

PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION — DENIAL

COUNTY STAMP

NOTE: *This notice relates only to your social services. It does* NOT *affect your receipt of SSI/SSP or Social Security.*
KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

CASE NUMBER

DATE MAILED

THE ITEMS CHECKED BELOW APPLY TO YOU:

☐ Your application dated _____ for In-Home Supportive Services has been denied because:

☐ Your application dated _____ for In-Home Supportive Services has been denied because your Share of Cost exceeds your need for services. This was determined as follows:

Your income that was counted: $ _____
Minus SSI/SSP benefit level: — $ _____
Your Share of Cost: $ _____

Your Share of Cost: $ _____
Minus Assessed IHSS Cost: — $ _____
Income in Excess of Assessed Cost: $ _____

SERVICES	HOURS ASSESSED
☐ **Domestic Services per Month:** Sweep, vacuum, etc; wash kitchen counters, etc; clean bathroom; store food, supplies; take out garbage; dust, pick up; clean oven and stove; clean, defrost refrigerator, bring in fuel; and change bed linen, make bed.	
☐ **Nonmedical Personal Services per Week:**	
Respiration Assistance	
Bowel, bladder care	
Feeding	
Routine bed baths	
Dressing	
Menstrual care	
Ambulation	
Move in/out of bed	
Bathe, oral hygiene/grooming	
Rub skin, repositioning, help on/off seats, etc.	
Care/assistance with prosthesis	
TOTAL NON-MEDICAL PERSONAL:	
☐ **Monthly Authorization:**	
Total weekly hours x 4.33:	
Add Domestic Services hours: +	
Add heavy cleaning/yard abatement: +	
TOTAL MONTHLY HOURS:	
Restaurant Allowance: $	

SERVICES	HOURS ASSESSED
☐ **Related Services per Week:**	
Prepare meals	
Meal clean up, menu	
Routine laundry	
Shopping for food	
Other shopping errands	
TOTAL RELATED:	
☐ **Transportation Services per Week:**	
Medical appointment	
To alternative resources	
TOTAL TRANSPORTATION:	
☐ **Protective Supervision per Week:**	
☐ **Teaching/Demonstration per Week:**	
☐ **Paramedical Services per Week:**	
☐ **Heavy cleaning (when indicated)**	
☐ **Yard hazard abatement (when indicated)**	

☐ The above action was necessary because of Federal and State Law and State Department of Social Services Manual of Policies and Procedures Section(s):

If you have any questions or think additional facts should be considered, contact:

Service Worker: _____ Telephone: _____

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING.
PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION - REASSESSMENT

NOTE: This notice relates **ONLY** to your Social Services. It does **NOT** affect your receipt of SSI/SSP or Social Security.
KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

CASE NUMBER

DATE MAILED

THE ITEMS CHECKED BELOW APPLY TO YOU:

☐ Effective ___/___/___ there is NO CHANGE from your previous authorization for In-Home Supportive Services.

☐ Effective ___/___/___ your authorization for In-Home Supportive Services has been changed.

☐ Total amount of your share of Cost: Was: _____ and is Now: _____ . This is a difference of _____ .
The new amount was determined as follows:

WAS		NOW	
Your income that was counted:	$	Your income that was counted:	$
Minus SSI/SSP benefit level:	—$	Minus SSI/SSP benefit level:	—$
Your share of cost:	$	Your share of cost:	$

SERVICES	PREVIOUS HOURS AUTHORIZED	HOURS NOW AUTHORIZED	INCREASE OR DECREASE
☐ **Domestic Services per Month:**			
Sweep, vacuum, etc.; wash kitchen counters, etc.; clean bathroom; share food, supplies; take out garbage; dust, pick up; clean oven and stove; clean, defrost refrigerator; bring in fuel; and change bed linen, make bed.			
☐ **Non-Medical Personal Services per Week:**			
*Respiration Assistance			
*Bowel, Bladder Care			
*Feeding			
*Routine bed baths			
*Dressing			
*Menstrual Care			
*Ambulation			
*Move in/out of bed			
*Bathe, oral hygiene/grooming			
*Rub skin, repositioning, help on/off seats, etc.			
*Care/assistance with prosthesis			
TOTAL Non-Medical Personal			
☐ **Monthly Authorization:**			
Total weekly hours x 4.33:			
Add Domestic Services Hours:			
Add Heavy Cleaning/Yard Abatement:			
TOTAL MONTHLY HOURS:			
Restaurant Allowance: $			

SERVICES	PREVIOUS HOURS AUTHORIZED	HOURS NOW AUTHORIZED	INCREASE OR DECREASE
☐ **Related Services per Week:**			
**Prepare Meals			
**Meal clean up, menu			
Routine laundry			
Shopping for food			
Other shopping errands			
Total Related Hours:			
☐ **Transportation Services per Week:**			
Medical appointment			
To alternate resources			
TOTAL Transportaion:			
☐ **Protective Supervision per Week:**			
☐ **Teaching/Demonstration per Week:**			
☐ ***Paramedical Services per Week:**			
☐ ***Heavy Cleaning*** (when indicated)			
☐ **Yard Abatement** (when indicated)			

☐ You are the only person counted in your household.

☐ You are receiving services based on _____ people living in your household.

☐ The reason for this change is:

☐ The above action was necessary because of Federal and State Law and State Department of Social Services Manual of Policies and Proceures Section(s):

☐ You have met the criteria of 20 hours or more per week in starred (*) services as prescribed by law which enables you to receive an advance payment to pay your own provider. **If you want to receive this advance payment, contact your services worker.** Double starred (**) services are included in the 20 hours **ONLY** when assistance with feeding is required.

You must report immediately, any changes that might affect your eligibility or need for In-Home Supportive Services such as a change in income, property, living arrangements, medical condition or ability to work. If you have any questions or think additional facts should be considered contact:

Service Worker: _____ Telephone: _____

You have the right to file a written or oral request for a State Hearing.

NA 890 B (11/83)

PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

IN-HOME SUPPORTIVE SERVICES
NOTICE OF ACTION — DISCONTINUANCE

COUNTY STAMP

NOTE: *This notice relates only to your social services. It does* **NOT** *affect your receipt of SSI/SSP or Social Security.*
KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

CASE NUMBER

DATE MAILED

THE ITEMS CHECKED BELOW APPLY TO YOU:

☐ Your eligibility for In-Home Supportive Services will be discontinued effective _____ because:

☐ Your eligibility for In-Home Supportive Services will be discontinued effective _____ because your Share of Cost exceeds your need for services. This was determined as follows:

Your income that was counted: $ _____
Minus SSI/SSP benefit level: — $ _____
Your Share of Cost: $ _____

Your Share of Cost: $ _____
Minus Assessed IHSS Cost: — $ _____
Income in Excess of Assessed Cost: $ _____

SERVICES	HOURS PREVIOUSLY AUTHORIZED
☐ **Domestic Services per Month:** Sweep, vacuum, etc; wash kitchen counters, etc; clean bathroom; store food, supplies; take out garbage; dust, pick up; clean oven and stove; clean, defrost refrigerator, bring in fuel; and change bed linen, make bed.	
☐ **Nonmedical Personal Services per Week:**	
Respiration Assistance	
Bowel, bladder care	
Feeding	
Routine bed baths	
Dressing	
Menstrual care	
Ambulation	
Move in/out of bed	
Bathe, oral hygiene/grooming	
Rub skin, repositioning, help on/off seats, etc.	
Care/assistance with prosthesis	
TOTAL NON-MEDICAL PERSONAL:	
☐ **Monthly Authorization:**	
Total weekly hours x 4.33:	
Add Domestic Services hours: +	
Add heavy cleaning/yard abatement: +	
TOTAL MONTHLY HOURS:	
Restaurant Allowance: $	

SERVICES	HOURS PREVIOUSLY AUTHORIZED
☐ **Related Services per Week:**	
Prepare meals	
Meal clean up, menu	
Routine laundry	
Shopping for food	
Other shopping errands	
TOTAL RELATED:	
☐ **Transportation Services per Week:**	
Medical appointment	
To alternative resources	
TOTAL TRANSPORTATION:	
☐ **Protective Supervision per Week:**	
☐ **Teaching/Demonstration per Week:**	
☐ **Paramedical Services per Week:**	
☐ **Heavy cleaning (when indicated)**	
☐ **Yard hazard abatement (when indicated)**	

☐ The above action was necessary because of Federal and State Law and State Department of Social Services Manual of Policies and Procedures Section(s):

If you have any questions or think additonal facts should be considered, contact:

Service Worker: _____ Telephone: _____

YOU HAVE THE RIGHT TO FILE A WRITTEN OR ORAL REQUEST FOR A STATE HEARING.
PLEASE SEE REVERSE SIDE OF THIS NOTICE FOR FURTHER DETAILS

RIGHT TO REQUEST A STATE HEARING

1. You have the right to a conference with representatives of the county social services department to talk about this intended action. At such a conference, you may speak for yourself or be represented by a lawyer, a friend or other spokesperson. If you want a conference, contact your county department.

2. Whether you request a conference or not, you also have the right to request a State Hearing and decision by the Director of the State Department of Social Services (see form below). Your request may be written or oral but it must state that you want a hearing and why you are dissatisfied. **YOUR REQUEST FOR A HEARING MUST BE MADE WITHIN 90 DAYS OF THE MAILING DATE OF THIS NOTICE.**

3. **IF YOU REQUEST A STATE HEARING ANYTIME BEFORE THE EFFECTIVE DATE OF THE COUNTY'S PROPOSED ACTION, YOUR SERVICES MAY CONTINUE UNTIL THE HEARING.** You will not be liable for repayment of services monies received pending the hearing, even if the result is a denial, provided your request is made in good faith.

4. You may request a State Hearing on your own, or you may ask your county department for assistance. In either case, however, be sure to inform your county department worker as soon as possible.

5. At a State Hearing you have the right to be represented by an attorney or any other person (a friend, relative, or other spokesman), of your choice. You may obtain free legal advice and the services of a lawyer. If free legal representation is available locally, the telephone number and/or address is listed above. You may also contact the nearest social service rights organization for assistance in presenting your claim.

6. State regulations governing State Hearings for social services are available at this office of the county social services department.

7. Information Practices - The information you are requested to provide is mandatory in order to process your request for a State Hearing pursuant to W&IC 10950. A case file will be established by the Office of the Chief Referee. You have the right to examine the materials that constitute the record for decision. Any information you provide may be shared with the county social services department or the United States Department of Health and Human Services.

If you wish to make a **written** *request for a State Hearing, please send this page to:*

Office of the Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

To make an **oral** *request for a State Hearing or further to obtain information about your State Hearing rights or files you may contact:*

Public Inquiry and Response
State Department of Social Services
(800) 952-5253 (toll-free number)*
TDD (800) 952-8349 * For Deaf Only

* *You may have to dial "1" first.*

REQUEST FOR STATE HEARING

Name (Last, First, Middle Initial) | Phone No. | Social Security No.

Address | City | State | Zip Code

I hereby request a State Hearing before the State Department of Social Services on the action taken by the County regarding my social services. The reasons for my request are as follows:

I have trouble understanding English, therefore I request an interpreter for my hearing in the following: | Language | Dialect

Signature | Date Signed

AUTHORIZED REPRESENTATIVE

I have authorized the following person to act on my behalf in my appeal. I authorize the Department to release any or all information about my case to that person.

Name of Authorized Representative

Address of Authorized Representative

Signature of State Hearing Applicant | Date Signed